RULE 29

FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY OR ILLNESS

A. In every case of reportable injury arising out of and in the course of employment, whether resulting from accident or from diagnosed occupational disease, the employer or its insurer or risk management pool shall file a report thereof with the compensation court, specifically stating the nature and extent of the injury. Such first report of alleged occupational injury or illness shall be filed within 10 days after the employer or insurer or risk management pool has been given notice or has knowledge of such injury.

B. Except as otherwise approved by the administrator of the compensation court, all first reports of alleged occupational injury or illness shall be filed electronically in the form and manner and to include the content prescribed by the administrator. With approval of the administrator, such reports may be filed by means of the paper First Report of Alleged Occupational Injury or Illness (Form 1), an exact copy of which appears on the two pages following this rule. The mandatory fields identified on the back of the Form 1 must be completed before the report will be deemed filed with the court. Blank forms for paper reports are furnished by the administrator upon request.

C. No report of alleged occupational injury or illness shall be deemed filed with the court until the report has been received and accepted by the court.

Sections 48-144, 48-144.01, 48-163, 48-165, R.S. Supp., 2005.
Effective date November 16, 2006.

Nebraska Workers' Compensation Court

First Report of Alleged Occupational Injury or Illness

NWCC Form 1
Revised 06/2006

Employer

Employer FEIN _____ SIC Code _____ Report Purpose _____ OSHA Log Case # _____

Employer Name(s) _____

Address _____

_____

City _____

State _____ Zip Code _____ Phone _____

Insured Name ***(If different from employer name)***

Insured Address ***(If different)*** Location _____

Insurance Carrier

Carrier FEIN _____

Administrator FEIN _____

Name _____

Address _____

_____

City _____

State _____ Zip Code _____ Phone _____

Policy Number _____

Policy Period: From _____ To _____

Insurance Carrier/Self-Insured Code # _____

Claim Administrator ***(Name, address & phone number)***

Self Insured ❑ ***Check if Appropriate***

Claim Administrator Claim # _____

Jurisdiction Claim # _____

Insured Report # _____ Jurisdiction _____

Employee

Name ***(Last, First, Middle)*** _____

Address _____

_____

City _____

State _____ Zip Code _____ Phone _____

Date of Birth | Social Security Number | Date Hired

Full Pay for DOI Yes ❑ No ❑

Salary Continued Yes ❑ No ❑

Number of Days Worked Per Week _____

Sex Male ❑ Female ❑

Number of Dependents _____

Occupational Job Title

Marital Status
Married ❑
Separated ❑
Unmarried ❑
Unknown ❑

Wage $ _____
Hourly ❑
Daily ❑
Weekly ❑
Bi-Weekly ❑
Monthly ❑

Occupational Code _____

Date Employee Began Work-Related Duties _____

Employment Status FT ❑ PT ❑ Other ❑

Occurrence/Treatment

Date of Injury/Illness

Time Employee Began Work AM ❑ PM ❑

Time of Occurrence (Cannot be determined ❑) AM ❑ PM ❑

Last Work Date

Where Did Injury/Illness Occur?
County _____ State _____ Zip _____

Did Injury/Illness Occur On Employer's Premises?
Yes ❑ No ❑

Date Employer Notified

Date Disability Began

Date Returned to Work

If Fatal, Give Date of Death

Type of Injury/Illness ***(Briefly describe the nature of the injury or illness; e.g. lacerations to forearm)***

Nature of Injury Code

Part of Body Affected ***(Indicate the part of the body affected by the injury/illness; e.g. right forearm, lowerback; and how it was affected)***

Part of Body Code

How Injury/Illness Occurred ***(Describe activity and tools, materials, equipment the employee was using; how injury occurred)***

Cause of Injury Code

Initial Treatment:
No medical treatment ❑
First aid by employer ❑
Minor clinic/hospital ❑
Emergency Room ❑
Hospitalized overnight ❑
Hospitalized > 24 hours ❑
Future major medical/lost time ❑

Name of physician or other health care provider:

Date Administrator Notified | Form Preparer's Name, Title and Phone | Date Prepared

General Instructions

*Items in bold are mandatory fields. First Report of Injury or Illness (*FROI*) without this information will be returned.*

Item—Definitions

Employer:

- Employer FEIN—the employer/insured's Federal Employer's Identification Number.
- SIC Code—Standard Identification Classification code which represents the nature of the employer's business.
- Report Purpose—defines the specific purpose of the transaction (examples: original=00; cancel=01; change=02; denial;=04; correction=co).
- OSHA Log Case #—the Log Case number required for reporting to OSHA.
- Employer Name—include all business names/doing business as *(dba)*
- Address (including city,state,zip)—the address of the employer's actual location where the employee was employed at the time of the injury.
- Phone—phone number at the employer's facility.
- Insured Name (*if different from employer*)—the named insured on the policy or the financially responsible self–insured employer.
- Insured Address (*if different from employer*)—mailing address of the insured.
- Location—a code defined by the insured/employer which is used to identify the employer's location.

Insurance Carrier:

- Carrier FEIN—carrier's Federal Employer's Identification Number.
- Administrator FEIN—administrator's Federal Employer's Identification Number.
- Name—the worker's compensation insurer, approved self insured, or intergovernmental risk management pool.
- Address— address of insurer (including city, state, zip).
- Phone—phone number of insurer.
- Claim Administrator (name, address, & phone)—enter the name, address and phone number of the carrier, third party administrator, risk management pool, or self–insurer responsible for administering the claims, if different from carrier information.
- Policy #—the number assigned to the contract/policy for that employer.
- Policy Period—the effective and expiration dates of the contract/policy.
- Insurance Carrier/Self Insured Code #—for insurance carriers, the number assigned by the Nat'l Assn. of Insurance Commissioners. For self-insured employers, the code number assigned by the court.
- Self Insured—check if appropriate.
- Claim Administrator Claim #—identifies a specific claim within a claim administrator's claims processing system.
- Jurisdiction Claim #—number assigned by the court when the initial First Report is accepted.
- Insured Report #—a number used by the insured to identify a specific claim.
- Jurisdiction—the governing body or territory whose statutes apply (NE).

Employee:

- Name—give full name as shown on payroll (avoid initials if possible).
- Address—enter employee's current mailing address (address lines 1 and 2, zip code, telephone information is optional).
- City and State—enter city and state where employee resides.
- Date of Birth—the date the injured worker was born.
- Social Security Number.
- Date Hired—the date the injured worker began his/her employment with the employer.
- Full Pay for DOI (date of injury)—check one.
- Salary Continued—check one.
- Number of Days Worked Per Week—the number of the employee's regularly scheduled work days per week.
- Sex—check one.
- Number of Dependents—the number of dependents as defined by the Nebraska Workers' Compensation Act.
- Marital Status—check one.
- Wage—check one and state wage.
- Occupational Job Title—the primary occupation of the claimant at the time of the accident.
- Occupational Code—Standard Occupational Classification code used to identify the primary occupation of the employee at the time of the accident.
- Date Employee Began Work–Related Duties—date pertaining to employee's present occupation.
- Employment Status—check one.

Occurrence/Treatment:

- Date of Injury/Illness—date on which the accident occurred (*only one date of injury per form*).
- Time Employee Began Work—time employee began work for that date.
- Time of Occurrence—time of day the injury occurred.
- Last Work Date—the last paid work day prior to the initial date of disability.
- Where Did Injury/Illness Occur—complete county, state, and zip code.
- Did Injury/Illness Occur On Employer's Premises—check one.
- Date Employer Notified—the date that the injury was reported to a representative of the employer.
- Date Disability Began—if not disabled answer none and skip questions.
- Date Returned to Work—if injured has returned to work, complete this question.
- If Fatal, Give Date of Death, (date employee died as a result of the work-related injury.)
- Type of Injury/Illness—describe the nature of injury.
- Nature of Injury Code—the code which corresponds to the nature of the injury sustained by the employee.
- Part of Body Affected—the part of the body to which the employee sustained injury.
- Part of Body Code—the code which corresponds to the Part of the body to which the employee sustained injury.
- How Injury/Illness Occurred—a free-form description of how the accident occurred and the resulting injuries.
- Cause of Injury Code—the code that corresponds to the cause of injury
- Initial Treatment—check one.
- Name of physician or other health care provider—provide name of physician or other health care provider that treated employee for injury.
- Date Administrator Notified—the date the claim administrator who is processing the claim received notice of the loss or occurrence.
- Form Preparer's Name, Title and Phone.
- Date Prepared—date form was actually completed.

Type or print neatly your response in ink.